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HEALTH CONCERNS OF ONTARIANS

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HEALTH CONCERNS OF ONTARIANS

by

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SUMMARY

This report concentrates on the current health concerns of Ontario residents. The research findings and discussions presented are drawn from a number of sources: governments, health associations, universities, community studies, health and social science journals, newspapers, popular magazines, and interviews. This report has been prepared at the request of the Creative Head, Home Studies, English Programming Services, to provide background information for the selection or development of health-related television programming with wide appeal.

The report separates the health concerns of Ontario residents into *personal health concerns* and *societal health concerns* with the final section profiling the *health status* of Ontarians. The implications for programming are derived from this research.

Personal health concerns identified as requiring further public awareness and education are:

- the impact of the environment on health
- alternatives to conventional health care
- food quality and nutrition
- childbearing and infertility
- fitness and exercise
- stress

Societal health concerns identified as requiring further public awareness and education are:

- AIDS and sexually transmitted diseases
- abuse of drugs, including legal drugs
- weight control
- effect of free trade on health care

The health status profile proposes these topics:

- changing public attitudes towards of the elderly and the health services available to them
- the effects of income and/or unemployment on health

RÉSUMÉ

Le présent rapport est une étude des préoccupations des Ontariens au sujet de la santé. Les résultats des recherches et les discussions qui y sont présentées ont été tirés d'un certain nombre de sources notamment des rapports gouvernementaux, des études de la Ontario Health Association, des études menées auprès de certains groupes, des articles tirés de publications sur la santé et les sciences sociales, des publications populaires et des entrevues. Ce rapport, rédigé à la demande du directeur de création, Études à domicile, Service de la programmation anglaise, renferme un ensemble de données sur lesquelles s'appuieront le choix ou la création d'émissions télévisées sur la santé destinées au grand public.

Le rapport présente les préoccupations des Ontariens sous deux catégories : il y a d'une part, les préoccupations personnelles et d'autre part, les préoccupations à l'échelle de la société qui exigent une plus grande sensibilisation du public. La dernière partie du rapport dresse un profil de l'état de santé des Ontariens.

Les *préoccupations personnelles* traitées dans ce rapport auxquelles le public devrait être sensibilisé davantage et sur lesquelles il devrait être mieux renseigné sont :

- l'impact de l'environnement sur la santé ;
- les soins de santé parallèle ;
- la qualité des aliments et la nutrition ;
- la maternité et l'infertilité ;
- la bonne forme physique et l'exercice ;
- le stress.

On a aussi relevé les *préoccupations à l'échelle de la société* auxquelles le public devrait être sensibilisé davantage et sur lesquelles il devrait être mieux renseigné :

- le sida et les maladies transmises sexuellement ;
- l'abus de drogues et de médicaments ;
- le contrôle du poids ;
- l'impact du libre-échange sur les soins de santé ;

Le *profil de l'état de santé des Ontariens* propose ces sujets :

- les effets du revenu et du chômage sur la santé ;
- la nécessité de changer la perception qu'on a des personnes âgées et les services de santé qui leurs sont offerts.

INTRODUCTION

This report describes the health concerns of Ontarians. It is based on an overview of research conducted by governments, health associations and universities, community studies, articles in health and social science journals, popular literature, and on interviews with sociologists who specialize in health. A profile of the current health status of Ontarians and the costs and definitions currently associated with health are included.

The report begins with the major issues listed as **suggestions for programming**. The subsequent sections provide the **context** for these suggestions, by citing research and studies on the nature of these issues and the populations concerned about them. Both the **personal** and **public health issues** are analyzed. Studies on the **health status** of Ontarians provide an **age-related** and **socio-economic** view of the health and the discussion of costs and definitions presents the **public policy** and **governmental perspectives**.

This report structure emphasizes the most significant information for TVOntario programmers, while still providing the essential context and explanation for the selection of topics.

The suggestions for programming that emerge from this study include many topics that have already been the subject of TVOntario programming. Nevertheless, these remain the most important current health concerns of Ontarians. Although each study cited in this report represents valid and important opinions, no synthesis to establish clear priorities or target audiences is possible. For the topics judged to be of most interest to TVOntario, Planning and Development Research can develop proposals that outline context and audiences more specifically. In addition, for more long-range planning, the social and economic developments expected in the next decade and their implications for public and personal health can be researched.

SUGGESTIONS FOR PROGRAMMING

Among Ontarians, the following were found to be matters of personal concern: environmental pollution and health: alternatives to conventional health care; nutrition; fitness and exercise; stress management; and childbearing and infertility. Four public health issues were also identified: sexually transmitted diseases and AIDS; the use of drugs, including over-the-counter drugs; weight control, including the issue of underweight among women; and the effect of free trade on the health system. The broader health status analysis suggests programming related to age and socio-economic. For each of these issues, topics that might be addressed by educational broadcasting are listed.

Several of the above topics have already been the subject of TVOntario programs. The following concerns have been selected as the most fruitful subjects for future programs:

1. the deterioration of the **environment** – what we know and don't know about its effects on health, and what we can do about it, individually and collectively; as well as the effects of the work environment on health, hazardous chemicals in the workplace; hazardous practices, assessing and correcting workplace danger.

2. the **health care system** and its **alternatives** – who does what in the health care system, the various alternatives to conventional medicine, training and licensing for different practitioners, the philosophy behind various alternatives.

3. **food quality** and **nutrition** – the known and unknown about nutrition and food additives; the new "environmentally safe" products, the safety of convenience foods.

4. **infertility** – its causes, its treatments, their success rates, and the emotional toll treatments take on participants.

5. **exercise and stress management** – the link between fitness and health, ways of improving the fitness levels of children, possible dangers of exercise, exercise as a stress management technique, the relationship between personality and stress, the nature of stress, and the most effective means of coping with it.

6. the **control** of **AIDS** and other **sexually transmitted diseases** – what are the real dangers, research and treatments, prevention, how to discuss the topic with teenagers.

7. use and misuse of **legal drugs** – the promotion and prescription of drugs, the role of doctors in perscribing drugs, effects of over-the-counter medications and interactions among them, women and drug use, alternatives to drugs, and positive approaches to quitting smoking and drug abuse, the signs and treatment of addiction.

8. **weight control and the thinness epidemic** – its social causes and effects on the self-esteem and physical health of women; issue of ideal weight, safety of surgical procedures.

9. the effect of the **free trade** agreement on Canada's health care system, how the system is changing, health care in the Canadian economy, the evolution and current state of our health care system.

10. the need to change **our attitude** toward, and **treatment of, the elderly,** the empowerment of seniors, the roots of the assumption that old age is a disease, positive health care alternatives and independence.

11. the link between **health and income,** the **effects of unemployment on health,** making better use of the health care system, and developing inexpensive but nutritious recipes.

HEALTH CONCERNS OF ONTARIANS

Ontarians have a broad view of health. A 1987 study by the Minister's Advisory Group on Health Promotion surveyed nine Ontario communities for their health concerns and interests. When asked what influenced their health, people included the following factors: environmental pollution, the amount of money they have, what they learn, their lifestyles, and the kinds of community and family resources available to them, such as transportation (especially for seniors), and daycare facilities (Minister's Advisory Group, 1987:6). Mental health appeared to be dependent on additional factors such as being considered worthwhile and of value to others and having power to affect one's own world (Caplan, 1989).

The health interests and concerns of Ontarians presented here have been drawn mainly from existing literature, and studies with experts in the sociology of health and illness (The list of interviewees is included at the end of the report). This section is divided into two parts: personal health concerns and societal health concerns. The first describes the issues that Ontarians consider directly relevant to themselves as individuals or to their families. The second section describes the issues that Ontarians consider to be crucial for our society as a whole but which may not be of concern to them personally.

PERSONAL HEALTH CONCERNS

The following topics emerged as those of the greatest personal concern in health-related matters. While health concerns related to the environment are clearly the most widely felt and are therefore discussed first, it was not possible to rank subsequent issues.

1. Effects of the Environment on Health

The public is very concerned about the effects of **environmental pollution,** in all its forms, upon their health. A Decima Research study (June 1989) showed that on a four-point scale ("not at all threatening," "somewhat threatening," "very threatening," and "immediately life

threatening"), 47% of Canadians said that air pollution was a very life-threatening problem, 46% said that dangerous drinking water was immediately life threatening, and 43% said that the diminishing ozone layer was very threatening.

In a similar 1987 study carried out by the Minister's Advisory Group on Health Promotion, environmental pollution topped the list of issues raised by the respondents. The study sought to identify the main health concerns of Ontarians through community dialogue with nine communities. Almost three-quarters of the respondents wanted to "live in an environment with clean air and clean water" (cited by Reed, 1989:7).

2. *Nutrition and Food Quality*

Nutrition was the top-ranked topic about which respondents to the 1988 Canada Health Promotion Survey wished further information (Health and Welfare, 1988: 202), and exactly two-thirds of the respondents felt that improving their eating habits would improve their health (Ibid., p. 146). A nutrition information study (Boyd-Withers, Gates and Hugenholtz, 1983) found that information about nutrition was being given to the public by a large number of professional groups in Ontario, including chiropractors, family physicians, and fitness instructors as well as nutritionists. Poor nutrition is not always a lack of information however. One low-income woman respondent that her obesity was due to poverty and that the poor simply cannot afford to eat according to Canada's Food Guide (Minister's Advisory Committee, 1987: 25).

Food quality is also an important concern for Ontarians and one that is related to an overall concern about the effects of pesticides on the environment. A decade ago, an opinion survey on **food additives** (Health and Welfare Canada, 1979) found that over two-thirds (68%) of the study's respondents disagreed with the statement: "I feel there is adequate control of food additives," and 87% agreed (49%, strongly) that they were concerned about the possible effects of food additives on their health. Over half (60%) indicated a willingness to pay more for additive-free foods. Although this study has not been repeated, there is no reason to expect that public interest in the topic has abated. In fact, the recent concern over the carcinogen, alar, in apples has probably

increased awareness of the food additives issue. A recent American survey of health concerns by the pollster Daniel Yankelovitch found that 78% of Americans polled wanted to "avoid food additives and other artificial chemicals in food."

The concern over food additives is particularly relevant to **children's health**. Twenty-three pesticides are used in the production of 27 fruits and vegetables. Relative to their weight, children eat six times as much fruit as women and have greater exposure to all but two of the chemicals found in pesticides. Toddlers are even more at risk. For example, the *Canadian Grocer* (July 1989:30) reported that toddlers receive 18 times as much exposure to UDMH (the carcinogenic breakdown of a fruit and vegetable pesticide) as adult women. This is 240 times the level acceptable to the U.S. environmental protection agency over a lifetime of exposure. In 1986, the U.S. Natural Resources Defense Council estimated that exposure to carcinogenic pesticides in the first six years of life accounts for more than half of a person's lifetime cancer risk.

Consumer trends are changing because of doubts about **food safety**. The *Northern Ontario Business* magazine (July 1989) reported that consumers are buying fewer fast foods and other convenience foods and more whole grains and foods with high fibre content. People are becoming less interested in convenience if it means jeopardizing the nutritional content of the food they buy. (*Bakers Journal*, July 1989).

Concern also exists about "fresh-refrigerated" foods. The new process of "fresh refrigeration" involves vacuum-packaging partially cooked foods to remove all the oxygen. Unfortunately, this process – a deadly, but highly undetectable toxin (MacDonald, 1988).

3. Childbearing and Infertility

Among women, who are the primary users of the health care system, pregnancy, childbirth, and breastfeeding continue to be of concern. One major issue is the treatment of **infertility**, mentioned by most of the experts interviewed. They were concerned about the extent to which the causes of infertility are ignored in favour of expensive research on developing new reproductive technologies, such as in-vitro fertilization. While widely touted as the answer for infertile couples,

success rates for this procedure are low and are often calculated differently at different centres. At an average cost of $1,500 per attempt in 1985 (Pilon, 1985: 22), the procedure is simply not an affordable option for most Canadians.

Problems such as infertility and impotence, miscarriages, still births and congenital birth defects may be partially due to hazardous chemicals in the **work environment**. This is a high priority issue for Ontarians working in manufacturing, according to Jim Brophy of the Windsor Occupational Health Information Service. Yet, apparently little is known about the effects of most chemicals on reproduction. Only 4-6% of all **birth defects** are known to be due partly to chemicals. (Zuckerbrot, 1987). Eighty percent of birth defects have completely unknown causes.

Of the many chemicals used, lead, mercury, and a number of pesticides are known to cause reproductive problems, but for every known substance there is one about which nothing is known. Two thousand new chemicals are synthesized each year and introduced into the environment, and it is almost impossible to know in advance if these cause reproductive problems in human beings. Birth defects and pregnancy complications represent the second-largest cause of person-years lost in Canada. Birth defects alone are the sixth-highest cause of premature years of life lost.

There are also other added stress factors connected to pregnancy and hazardous chemicals in the workplace. Employers have a tendency to remove pregnant employees from hazardous positions for the duration of their pregnancy rather than to make the workplace safer for all.

4. Alternatives to Conventional Health Care

In keeping with their wide-ranging view of health, Ontarians want and use **alternatives to the conventional health care system.** The Minister's Advisory Committee community study found that people expressed a desire to choose alternative and complementary therapies, and were worried about having to bear the full cost of alternative care themselves (Minister's Advisory Group, 1987: 21). There is an expanding array of health care practitioners, both in the conventional

specialties, and in the alternative approaches, such as chiropractic, osteopathy, homeopathy, naturopathy and holistic medicine. Indeed, the variety of health care options is now so dizzying that one almost needs a guidebook to figure out who does what, what the licensing requirements are (if any) of the various specialties, and which ones are covered by OHIP.

Chiropractic, for example, has enjoyed a long history in Canada. It has been licensed since 1925 under the Drugless Practitioners Act, and since 1969 has been covered by OHIP – to a limited extent. The proportion of the population that visits chiropractors rose from 0.9% in 1950 to an estimated 6 to 10% by the mid-1980s (Biggs, 1987: 335).

A willingness to recognize alternatives to conventional health care is also revealed by an item in a 1986 Ontario Hospital Association survey that investigated attitudes towards **midwifery**. Forty-three percent of the respondents agreed that midwives should be able to practise out of homes as well as hospitals and birth clinics, whereas only about a quarter (26%) wished to restrict midwives to hospitals. In addition, alternative journals such as the feminist *Healthsharing* and the holistic medicine newsletter *Hologram*, as well as consumer groups such as the 8,000-member Association of Concerned Citizens for Preventive Medicine are signs of the public's interest in charting their own health care course, even when it takes them away from the traditional doctor's office.

5. Fitness and Exercise

People believe that **exercise** is beneficial to their health. Over half (57.6%) of the Ontario respondents in the 1988 Canada's Health Promotion Survey thought that more exercise would benefit their health, and 60% of those who thought they should do something to improve their health, believed that more exercise was the most important measure to take (Health and Welfare Canada, 1988: 159). Happiness was also found to be positively related to frequency of exercising. The main reason given for not exercising more was lack of time (34%) followed by lack of self-discipline or energy (17%).

Although there is widespread awareness of the link between **fitness and health**, many people consider physical fitness and recreation to be middle-class activities (Minister's Advisory Group, 1987: 23). Comments from those who work with low-income people suggested that "there is too much focus ... in health promotion right now... on smoking and fitness. There needs to be less jargon and more specific and practical attention paid to the needs of poor people" (Minister's Advisory Group, 1987: 18).

There is also growing concern over the **fitness of children**. Children are 40% less fit than they were 30 years ago. This has caused alarm among physical fitness educators who fear that we're raising a generation of "couch potatoes" (Bula, 1988).

6. Stress

Another area of concern to people is **stress**. In the 1987 community study cited above, stress was seen as an important determinant of overall health (Minister's Advisory Group, 1987: 5). Yankel Jovanovitch's American poll (cited in Reed, 1989: 7) found that "the most widespread vexation, confounding 80% of those polled, was the inability to lessen their worries in life." In addition, 78% were concerned with "managing to do everything I have to, without fraying my nerves," and 75% were worried about "having enough time for leisure and recreation." Clearly, then, coping with stress ranks high in people's health-related concerns, and the fact that suicide is a leading cause of death among young people is a disturbing testimonial to the need to find ways of coping better with stress and anxiety in our society.

The type of city or community one lives in may also contribute to stress. A Toronto architect, Eberhard Zeideler, claims that it's ugly cities, not **population density**, that actually pose a major challenge to mental health. "People get lost in the visual cacophony and feel overpowered by all the visual stimulus in cities," (Harris, 1988). In large cities, such as Toronto, stress is further exacerbated by the increasing number of traffic jams, long lines for banking and buying groceries, and rising noise levels (Scotton, 1989). With the trend to increased urbanization, such stress will probably continue.

Stress is an even greater problem for **women, minorities,** and **immigrants,** who face a combination of added problems such as difficult employment situations, separation from families, unfamiliarity with the language, and negative public attitudes. A 1984 study by the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees showed that at least 15% of Canadians are blatantly racist and 20-25% have racist tendencies (Doyle, 1989). Such tendencies create stress for entire immigrant families but seem to be more intense for immigrant women and children.

Research is also finding, however, that **personality type** may have a strong influence on stress and are looking at ways to encourage the development of positive personality traits in order to reduce stress. Pessimists, or people who tend to be more "in touch with reality" and who therefore have more information about what can go wrong, tend to concentrate on the negative side of situations. Optimists tend to do better in the job market and in personal relationships and rebound faster from life-threatening experiences. But they also have a general expectation that good things will somehow happen (Bass, 1988).

SOCIETAL HEALTH CONCERNS

1. Sexually Transmitted Diseases/AIDs

No report on health concerns today can avoid mention of **sexually transmitted diseases (STDs)** in general, and **AIDS** in particular. In this report, AIDS is discussed as a societal concern because a 1988 Gallup poll showed clearly that the majority of Canadians do not consider AIDS to be a personal health issue (Gallup Canada 1988a and 1988b). The poll asked Canadians what they believed to be the "most urgent health problem facing the country." Their responses ranked as follows: AIDS—57%, followed by cancer—24%, heart disease—6%, senility—1%, alcoholism—1%, drug abuse—1% and pollution or radioactivity—1%. In Ontario, 60% of respondents rated AIDS as the most urgent health concern, 19% said cancer, 7% said heart disease, and 10% listed other problems.

Despite the overwhelming concern about AIDS, the Gallup study also revealed that 81% of Canadians did not believe they had to change their **sexual behavior** in any way in order to avoid the risk of AIDS. All of the respondents in the Gallup study were adults over the age of 18. Of these, only 7% were seriously thinking of changing their sexual behavior in order to avoid the AIDS risk. However, the poll did find that in Toronto and Montreal, Canada's two largest cities, the percentage of people who have changed their behavior because of AIDS (11% in Toronto) was somewhat higher than the national average.

Younger people are only slightly more worried about developing AIDS. Only 14% of college and university students who report having sexual relations often say they *always* use a condom. A recent study of Canadian youth and AIDS found that although there is anxiety about AIDS among young people, it has not greatly altered their sexual behavior (Tripp and Davenport, 1988/1989). The study shows that an alarming number of young people who are sexually active engage in behaviour through which infections can be transmitted. This suggests that there is still a need for education about AIDS and about STDs in general.

2. *Drug Abuse*

Tobacco and alcohol addiction have been a major focus of Canada's health promotion efforts for over a decade, and the dangers of these substances are well documented. Most disturbing is the extent to which young people use alcohol, tobacco, and other drugs. One 1981 study (Vingilis, De Genova and Adlaf, 1986) found drinking and driving to be alarmingly prevalent among young people, although comparisons with 1977 and 1979 studies did show a downward trend. About half of the students said that, sometime in the previous year, they had driven within one hour of having two drinks. Twenty percent of the licensed drivers had been in at least one collision in the past year, and five percent had been in at least one drinking-driving collision.

Research on educational efforts to discourage **smoking** shows that messages which try to instill a fear of smoking are unsuccessful. Audiences are more receptive to positive messages which treat smokers as adults and point out the addictiveness of tobacco. Fear tends to paralyze people into inaction or makes them smoke even more (Tripp and Davenport, 1988/89).

Although almost everyone is aware of the dangers of using illicit drugs, the use of **legal drugs** has also permeated our culture. A 1983 community health survey of Toronto residents found that fully 40% had taken medication or drugs of some kind within the previous two days (City of Toronto, 1983). Twenty percent of all drugs taken were nonprescription, and women were more likely than men to have taken something. Among Canadian women aged 15 and over, another

study (Health and Welfare Canada, 1988: 51) found that 10.1% (as compared to 6.1% of men) had taken sleeping pills in the past 12 months and 8.1% (6.7% of men) had taken tranquilizers such as Valium. These figures raise questions about the widespread reliance on drugs, their effects, and the possible interactions among different drugs.

3. Weight Control

Various studies have documented the problem of **obesity** and its links with health. Almost one-third of Canadians weigh more than they should for optimum health. Canada's health promotion survey (Health and Welfare, 1988: 150) found 15.2% of Canadians to be somewhat overweight and another 16.9% clearly overweight. In Ontario this would amount to over 2,200,000 adults above their ideal weight.

Equally startling, however, though less frequently noted, is the high number of **underweight women**. In total, over one-fifth (21.5%) of women over the age of 20 were classified as underweight in this same Health and Welfare survey. The largest proportion, 25.1%, were in the 20-to-24 age group. Only 5.6% of men were found to be underweight.

What is most alarming is the fact that almost two-thirds of all women (63.8%) wish to lose weight. This includes 22.9% of those who are underweight, and 68.5% of those with acceptable weights (Health and Welfare, 1988: 151). Certainly, these numbers reveal a major discrepancy between what women believe to be desirable weights and what experts consider to be normal, healthy weights.

The disease which reflects our cultural obsession with thinness is **anorexia**. Studies of high school girls show an enormous preoccupation with weight loss. One Saskatoon study of grades 10 and 12 students found that 76% of the grade 12 girls reported dieting, and that of those, 12% report using dieting aids, 17% vomiting, and 7% purgatives. This compares to a 1984 Manitoba study that found 22% of females aged 12-20 display maladaptive eating behaviors (Currie, 1988: 199). In Currie's view, anorexia is a sociosomatic illness and must be understood sociologically, in terms of our consumer society which makes such a fetish of the thin female form that women come to view

their bodies as mere commodities that must be altered to fit this unrealistic ideal.

A health issue connected to weight and women's negative self-image is the risk posed by **surgical procedures**, such as breast implants and liposuction. In Canada more than 12,000 women a year obtain breast implants. There is growing concern about health problems resulting from polyurethane foam-covered breast implants, as polyurethane is suspected to be carcinogenic. Other types of implants tend to cause severe scarring (Comeau, 1989). In January 1990, a dramatic court case, following the death of woman who had liposuction, has raised questions about the safety of such surgical procedures.

4. *Effect of Free Trade on Health Care*

One issue raised by the Consumer Advisory Panel on Seniors' Health Issues (Ontario Hospital Association, 1988) was the effect of free trade on Canada's health care system. Although Canada's **universal health care** system may not be threatened, growing U.S. investment in private nursing homes can be expected. With the introduction of free trade, Canadian industries that produce and trade in medical devices, pharmaceuticals, and biological products may be in danger of foreign domination. The development of an advanced Canadian **biotechnology** industry would be greatly hampered by current and expected foreign ownership, such as the foreign takeover of Connaught Laboratories (Rowan, 1989:A7). Although these issues are not of widespread concern at present, foreign control of the availability of health products could become a greater worry to particular groups.

HEALTH STATUS

In this section, the health status of Ontarians is profiled by reviewing life expectancy, socioeconomic conditions, and the cost and definition of health care.

Life Expectancy

There have been major gains in **life expectancy** for both males and females over the past half century. For women, life expectancy increased from 62.1 years in 1931 to 79.7 years in 1986-87; the corresponding gain for men was from 60.0 years in 1931 to 73.5 years in 1986-87. As well, deaths from **heart disease** declined by 28% for men, the main victims, between 1976 and 1986-87 (Statistics Canada, 1987).

On the negative side, however, **cancer** rose by 15% between 1971 and 1981 (Hay, 1988: 27). Particularly striking is the fact that female mortality from lung cancer has increased 45% over the last decade. Lung cancer is expected to overtake breast cancer as the leading cause of cancer death in women within five years (Trypuc, 1988: 158), having moved from ninth to second place over the last fifteen years (Burke, 1986: 25).

Smoking is the main reason for this shift, and there are some very disturbing trends among women. In 1985, female teenagers (25%) were more likely to smoke than male teenagers (21%) (Trypuc, 1988: 158), and the percentage of 20-to 24-year-old women who smoke daily is estimated to have risen from about 40% in 1983 to 52% in 1985 (Edwards, 1986: 9). The corresponding increase for 25-to 29-year-old women was from 34% in 1983 to 47% in 1985. Although smoking is now decreasing, it is doing so at a greater rate among men than women.

For young people aged one to 34, **accidental and violent deaths** are the leading causes of hospitalization and death (Burke, 1986:25). Motor vehicle accidents, many of them alcohol-related, are the top killers among 15- to 24-year-olds, with other accidents ranking second, and suicide, third (Hay, 1988: 22). Suicide rates have increased markedly for men aged 15 to 24, moving from 5.3 of deaths per 100,000 population in

1960, to 30.8 in 1985. The rate has remained fairly stable for young women: 1.2 in 1960 and 4.2 in 1985 (Statistics Canada, 1988:22-24).

The situation for **Native Canadians** is the most dismal by all measures, from infant mortality to life expectancy (Morrison et al, 1986). In 1960 the Native infant mortality rate per 1,000 live births was 79.0 compared to 18.8 for Canadians as a whole. By 1984 both rates had declined, but the Native infant mortality rate was still much higher at 27.3 per 1000 live births compared to 8.2 for Canadians in general. This is especially significant when one considers that 50% of the Native population is under 20 years of age and that there is a 10-year difference in life expectancy between Native people and the rest of Canadians (Pekeles, 1988).

With the exception of AIDS and other sexually transmitted diseases (STDs), **infectious diseases** are no longer the danger to Canadians that they once were. Only among pre-school children in daycare are infectious diseases a serious problem. Children in daycare have a three or four times higher rate of infection than those who are not in daycare. This applies particularly to children under the age of six, with most of the infections tending to be respiratory and digestive. Children outside daycare usually get diarrhea once a year, whereas children in daycare are likely to suffer from diarrhoea up to four times a year. The real worry is not about children two years old and above, however, but about infants and toddlers, who still have very low resistance to infections. (Bremmer, 1988; Abramovitch, 1988).

A final trend concerns the **aging population**. In 1985, 28.5% of the Ontario population were under 20 years of age, 60.8% were between 20 and 64, and 10.6% were 65 or older. This last group is expected to increase to 14.4% of the population by the year 2006 – a substantial growth. The largest increase is expected to occur in the over-85 group, which will more than double in size, from 90,500 to 194,700 in 2006 (Chambers, 1987: 2).

This shift in the age structure of the population is bound to have repercussions on the **health care system**. But the extent of the impact is vigorously debated among the experts (Chambers, 1987: 3; Hertzman and Hayes, 1986; Angus, 1987). There is evidence to suggest that, despite common perceptions of the elderly as frail and disease-ridden, the reality is quite different. One Manitoba study (Roos, 1987) found

the great majority of seniors in that province to be healthy and infrequently hospitalized, a fact that leads Roos to suggest that the main problem is not excessive demand by seniors for health care, but the tendency of physicians to **medicalize the problems of the elderly** and to overprescribe drugs for them.

A recent Ontario Hospital Association panel on seniors' health issues, comprising eleven opinion leaders, all seniors themselves, stressed that an important problem was **attitudes towards seniors**, especially the alleged negativism of health care professionals (OHA, 1988a: 12). A public opinion survey commissioned by the Ontario Hospital Association in 1986 found that Ontarians over age 45 used the services of a general hospital less often during a one year period than did younger age groups (OHA, 1986: 3). The main challenge for the future, then, is to alter our attitudes towards seniors and to find ways to prolong their independence through home care and other support services.

Socioeconomic Status

An important finding of all studies of mortality and disease in Canada is the extent to which **socioeconomic status** determines health and longevity. To put it bluntly, the poor die earlier and live less healthy lives than the middle classes or well-to-do. There is a six-year difference in life expectancy for men and a three-year difference for women between the poorest 20% of the Ontario population and the richest (Chambers, 1987: 5). Wilkins and Adams (1987) also found that the healthfulness of life in Canada was directly related to income, regardless of how health was measured. They propose a new "quality-adjusted" life expectancy measure that takes into account not just the number of years lived, but includes factors such as restriction of activity due to ill health. With this measure, the discrepancy between the poorest and wealthiest 20% of the population was 11 years of "quality-adjusted" life. As well, low-income men can expect to experience almost twice the years of disability of high income men, despite shorter lives, and women can expect 40% more years of disability (Chambers,1987:5).

Not surprisingly, **unemployment** is also found to be related to health. Substantial health differences have been found between employed and unemployed individuals (Hay, 1988: 31-32). Several studies have also found relationships between the country's unemployment rate and the health status of the population as measured by mortality and morbidity rates (Hay, 1988: 31).

If unemployment is bad for health, what about employment? One of the most rapidly expanding areas of research in the health field examines work as a determinant of health and illness, including both the **physical work environment** and **psychosocial aspects** such as stress and alienation (Coburn et al. 1987: 104). The statistics on accidents at work are quite shocking. Every 2.1 hours of a working day, a work-related death occurs in Canada, and the cost of workers' compensation claims has gone from $156.5 million in 1972 to $620.5 million in 1981, though the number of claims has remained fairly stable at about 385,000 per year (Chambers, 1987: 14). Yet, 39% of workers were not aware of any **accident prevention** programs where they worked, although 60% believed that it was very important for the government to deal with accident prevention on the job (Health and Welfare Canada, 1988: 123).

As well, the number of workers who become ill or die yearly in Ontario from exposure to **hazardous chemicals** at work is estimated at 150,000 (Chambers, 1987: 14). Clearly, there is an important link between work and health, especially in Ontario, where the majority of Canada's manufacturing jobs are located.

The connection between work and health may become an even larger issue in workplace and labor politics as the economy worsens. People will have fewer opportunities to change jobs if they are worried about chemical hazards at work or other stresses that affect their mental health (Livesey, 1988).

Costs and Definitions of Health

Personal health is a major factor in the quality of life, and **health care systems** are funded to a large extent by tax dollars. As we all know, health care in Ontario is expensive. In 1985-86, for example, the Ontario Ministry of Health's budget consumed almost one-third (32%), or $9.26 billion, of the provincial government's total expenditures (Evans, 1987: 7).

Canada's health care costs are high but comparable to those of other industrialized nations, although the privately funded American system is more expensive. In 1987, American health care costs amounted to 10.5% of the Gross National Product, whereas in Canada, they represented 8.4%.

Hospital-related expenses are the main costs in Ontario, accounting for 62% of health care spending in 1985-86. An additional 30% of expenses were payments for Ontario Health Insurance Plan (OHIP) fees-for-services; 89% of this money went to physicians (Evans, 1987: 7-8).

This emphasis on funding hospitals and physicians reveals the bias in our health care system towards treating illness rather than promoting health. Since 1974 there has been sustained effort on the part of the federal government to **stress prevention and health promotion** and to stop defining health as simply the absence of disease. The then Minister of Health, Marc Lalonde, issued a document proposing a "health field concept," which recognizes four factors influencing health: (1) human biology, (2) environment, which includes factors external to the individual over which she or he has no control, (3) lifestyle, or the aggregate of decisions by individuals which affect their health and over which they more or less have control, and (4) health care organization, or what we would normally term the health care system (Lalonde, 1974:32).

Lalonde's report has become the blueprint for government health promotion efforts in the fifteen years since it was written. The greatest emphasis has been on **promoting healthy lifestyles** among individuals, with topics such as diet, exercise, smoking, alcohol, and drug use becoming major issues for health educators. Although these are certainly important matters, an over-emphasis on individual lifestyle can lead to a kind of "blame the victim" thinking which avoids taking

political and social responsibility for health. In recent years, Lalonde's successors have been criticized for downplaying the influence on health of both the physical environment and the social, political, and economic contexts (Bolaria, 1988; Buck, 1986; Chambers, 1987).

The current definitions of health recognize that physical and emotional well-being has many dimensions. In 1986 Jake Epp, the then federal Minister of Health and Welfare, proposed that health be viewed broadly, as a part of everyday life and an essential component of quality of life; **quality of life** referred to the opportunity to make choices and gain satisfaction from living. He stated that health is "a resource which gives people the ability to manage and even to change their surroundings ... a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments."

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